C+D

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30 May 2009

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United we stand...

Pharmacists focus on Westminster in campaign to decriminalise dispensing errors

See pages 6 and 7

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2008.03.03-EC172

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PDA ABC

TABPI Awards 2008
Winner for news coverage

> THE ELIZABETH LEE CASE HAS CLEARLY TOUCHED A RAW NERVE AMONG COMMUNITY PHARMACISTS

The momentum behind Dispensing Justice, the campaign to decriminalise dispensing errors, is fast gathering pace and is impossible to ignore.

Such has been the widespread shock and outrage at the jail sentence – albeit suspended – given to locum Elizabeth Lee for making a dispensing error that was not linked to the death of a patient, that a number of the sector's key organisations, as well as MPs, have publicly voiced their fears over the ramifications (pages 6 and 7).

Representative groups for employers, employees, locums and individual pharmacists have all gone on the offensive to highlight the disproportionate way that pharmacists are punished compared to their healthcare peers.

And next weekend sees the first public meeting on the issue as the PDA hosts an event at London's School of Pharmacy (p7). With speakers from the National Patient Safety Agency as well as a member of Mrs Lee's defence team, the event will be an early barometer of the strength of feeling for change among grassroots pharmacists.

The PDA gathering will be followed 10 days later with a meeting at Westminster, as MPs launch an investigation into decriminalising dispensing errors (p7). The all-party pharmacy group says that while gross negligence and deliberate mistakes should lead to appropriate penalties through regulatory and legal processes, that situation is a world apart from putting a health professional at risk of a criminal conviction for reporting a genuine mistake.

This gulf is perhaps the nub of this particular issue – and one that pharmacists need to make sure they do not lose sight of. From our perspective, this campaign is a no-brainer. But this very conviction could so easily be misconstrued as an act of self-preservation by the very group that we need to get on side, our patients.

The campaign must not alienate patients. As PSNC chief executive Sue Sharpe says (p7), it must not be seen as a way of pharmacists avoiding punishment for their failings.

Treating pharmacists in the same proportionate manner as other health professionals does not preclude patients from seeking redress through civil action, nor does it prevent criminal action against those who wilfully put patient lives at risk, and this needs to be made clear to those whose support is needed.

The Elizabeth Lee case has clearly touched a raw nerve among community pharmacists. Emotions are running high, but while there is much to gain from a united, cohesive industry response, there is even more to lose if pharmacy is seen to be shirking its responsibilities.

Gary Paragpuri, Editor

Features

Society enlists members in fight

CAMPAIGN Case for decriminalisation of dispensing errors gathers momentum

Chris Chapman

The Royal Pharmaceutical Society will seek to enlist pharmacists across the country in the fight to decriminalise dispensing errors, its president has said.

The announcement came as the Society outlined its plan to campaign for a change in the law, and grassroots pharmacists seized the initiative to take the fight to Westminster.

At the RPSGB branch representatives meeting last week, president Steve Churton said the Society would email pharmacists across the country, urging them to press their MP to call for an end to the criminal prosecution of dispensing errors. He said: "Plans are in hand to help lobby MPs, and members will get an email from us on how to do that."

Society head of public affairs Charles Willis told C+D the emails were one of several moves the Society will make to push for the decriminalisation of dispensing errors. Mr Willis said the Society's campaign plan will include:

Attending the all-party pharmacy group meeting on June 16, and making a request for MPs to sign an Early Day Motion (EDM).

Urging pharmacists to ask their constituency MP to sign the EDM. A prepared letter will be available at www.rpsgb.org this week.

Discussing the issue of decriminalisation with both major opposition political parties.

Encouraging all pharmacists to sign the petition to decriminalise errors at www.gopetition.com/petitions/decriminalisation-of-dispensing-errors.html.

Engagement with "senior figures", both in Whitehall and at Westminster.

Society registrar Jeremy Holmes had already spoken to shadow health minister Mark Simmonds MP about decriminalisation, Mr Willis added. Mr Simmonds confirmed to C+D that he was looking at the issue "extremely carefully".

Mr Willis's comments came as the RPSGB's Chiltern region announced it would hold a conference at Westminster to lobby MPs to end prosecution over dispensing errors.

The conference, which will include MPs from all major political parties, will be held at Portcullis House on June 23. To attend the meeting, email Shilpa Gohil at secretary@handhbranch.org.uk.

Dispensing errors topped the agenda at last week's RPSGB branch reps meeting

Lee case creating a climate of fear

Pharmacists are more concerned about long working hours and a lack of breaks following the Elizabeth Lee case, a support charity has told C+D.

Pharmacist Support had noticed an "underlying current of fear of making an error" since the former locum was last month given a suspended prison sentence after a dispensing error, said charity manager David Qualtar.

He said: "There's certainly been a feeling that people are more aware of the dangers of mis-dispensing."

Almost half of calls to Pharmacist Support's stress helpline in the past year were from pharmacists working at large multiples, nearly a quarter at small chains and 15 per cent at independents. Mr Qualtar said: "There does seem to be an issue with the large multiples, and maybe that's increasing targets without increasing resources."

The charity (formerly The Benevolent Fund of the Royal Pharmaceutical Society) had also recently seen an increase in the number of young pharmacists calling the Listening Friends helpline – over 50 per cent of calls were now from the under-30s. **JR**

Patient deaths and the law
See p20

Accused 'too compliant' in error investigations

Pharmacists must be more robust when facing investigations into dispensing errors, a legal expert has claimed.

Pharmacist and barrister Graham Edwards said they should not answer initial questions that may incriminate them, without seeking legal advice.

"The problem is, whether through training or tendency, pharmacists tend to be compliant people who want to please," Mr Edwards told a seminar held by the Pharmacy Law and Ethics Association (PLEA) last week.

"This can lead to them answering questions without legal advice that may later incriminate them when they should initially just say 'no comment'."

Refusal to comment could conflict with the Society's Code of Ethics or with contractual obligations to an employer or PCT, Mr Edwards pointed out. But in some cases the pharmacist may need to consider whether risking their employment position was more or less serious than the possibility of a custodial sentence or putting their professional registration at risk.

Speaking on behalf of the Pharmacists' Defence Association, Mr Edwards said that doctors and other professionals were more assertive when facing investigations "because they have to be to do their jobs". **JC**

WHAT YOU CAN DO: how you can support the Dispensing Justice campaign to decriminali

DISPENSING JUSTICE

Attend the PDA 'call to action' meeting at the School of Pharmacy, University of London, on June 7 at 1.30pm. Register at **www.the-pda.org**

The online petition to decriminalise dispensing errors now has almost 12,000 signatures. Add yours at **www.gopetition.com/petitions/decriminalisation-of-dispensing-errors.html**

Contribute to the PDA's Fighting Fund, to overturn the conviction of Elizabeth Lee and secure the decriminalisation of dispensing errors. Make a contribution at **http://tinyurl.com/qsuefj**

Pharmacy leaders united in campaign support

CAMPAIGN PSNC backs change in the law '100 per cent'

Jennifer Richardson

Leading pharmacy organisations and companies have pledged their support for a sector-wide campaign for the decriminalisation of dispensing errors.

PSNC chief executive Sue Sharpe said the contract negotiator was "100 per cent" behind a change in the law.

"There's a strong case for saying that this strict criminal liability is incompatible with a proper learning culture in which pharmacists are open in reporting errors and learn from experience," she said.

NPA chairman Ian Facer agreed that the current law "compromises learning and improved practice", and mandated the association to support moves to decriminalise dispensing errors.

And Day Lewis superintendent Peter Glover told C+D the Elizabeth Lee case (in which a locum received a three month suspended prison sentence following a dispensing error) had "set patient safety back years". He added: "Anything that can be done to decriminalise dispensing errors as soon as possible should be done."

However, Ms Sharpe warned those intending to lobby their MPs to be careful when representing the argument for the decriminalisation of dispensing errors. "We have to be sensitive to ensure that the victims of errors don't feel like this is pharmacists seeking to avoid responsibility," she said.

"It's about ensuring that we have the best framework for accountability that doesn't interfere with the principle of learning from mistakes."

MPs and PDA to debate issues

The all-party pharmacy group (APPG) and the Pharmacists' Defence Association (PDA) have both this week unveiled details of their investigative meetings on decriminalising dispensing errors.

The APPG pledged to scrutinise the "disproportionate treatment of human error" at its June 16 Westminster meeting, where speakers are set to include England's chief pharmaceutical officer Keith Ridge and NPA chairman Ian Facer.

Criminalising mistakes "threatens progress" towards new pharmacy services and health promotion, the cross-party group of MPs said.

And the PDA unveiled its June 7 meeting at the University of London School of Pharmacy. Professor David Cousins, head of safe medication practice at the National Patient Safety Agency, will speak on "Why a learning culture and not a blame culture will always be in the patient's best interests". PSNC chief executive Sue Sharpe and PDA chairman Mark Koziol will also be speaking. **JR**

A Lancashire MP has pledged to write to health secretary Alan Johnson about the decriminalisation of dispensing errors, following a Building Bridges visit. Labour MP for South Ribble David Borrow visited Preston's Hesketh Bank Pharmacy as part of an awareness day on type 2 diabetes in children and young people, organised by pre-reg pharmacist Caroline Lambe. Ms Lambe, pictured carrying out health checks on Mr Borrow, took the opportunity to express the profession's concerns about pharmacists facing criminal charges for dispensing errors. Mr Borrow has confirmed to C+D that he will now write to the health secretary about the issue. He said: "The key thing is to make sure that the people at the top are aware of these concerns."

EU ruling

Pharmacy ownership can be restricted to pharmacists alone, Europe's top court has ruled in a landmark case. The European Court of Justice ruling upholds legislation in Italy and Germany, where bans are imposed on the third-party ownership of pharmacy premises.

CPW chair changes

Community Pharmacy Wales chairman Phil Parry has stepped down from the post after 12 years. Rowlands Pharmacy's Ian Cowen took the chair with unanimous support, and Mr Parry will now act as vice chair.

New oral contraceptive

An oral contraceptive that delivers estradiol, the oestrogen produced naturally by women's bodies, is available for the first time in the UK. Qlaira boasts an 80 per cent satisfaction rate, according to manufacturer Bayer.

PLEA re-elections

Professor Joy Wingfield and Dr Gordon Applebe have respectively been re-elected as chair and secretary/treasurer of the Pharmacy Law and Ethics Association at the organisation's AGM last week. Neither was opposed.

Society AGM honours

Former RPSGB secretary and registrar Ann Lewis was awarded the Gold Charter Medal at the RPSGB Council's 2009 AGM. The Council gave the Silver Charter Medal to Company Chemists' Association chairman Digby Emson, and the 2009 Synergy Award to Howard Stoate MP, chair of the all-party pharmacy group.

www.chemistanddruggist.co.uk

spensing errors

Ask your local MP to sign an Early Day Motion (EDM) supporting the decriminalisation of dispensing errors. A template letter will be available at **www.rpsgb.org** this week.

Attend the RPSGB Chiltern branch's Westminster meeting at Portcullis House on June 23. To attend, email Shilpa Gohil at **secretary@handhbranch.org.uk**

Sign up to C+D's newsletter to be kept up to date on the campaign's progress. Register at **www.chemistanddruggist.co.uk/register**

Find out more about C+D's new MUR accreditation course

...for MURs – ...new MUR ...accreditation course ...from Medway ...C+D is launched

...new ... course ... this ... Medway ... pharmacy.

Endorsed by PSNC, Skills for MURs uses printed learning materials covering both the MUR process and commonly encountered therapy areas, plus online assessment where students are asked to watch a video of an MUR interview and review a PMR before completing an MUR form.

Learning materials and the assessment process (£195 ex VAT) can be purchased separately or as a package. For more information about the course and how to register go to www.skillsformurs.co.uk.

Skills for MURs is part of the Medway Short Course Pathway, and successful students will receive five academic credits that can accrue towards a postgraduate Certificate.

Skills for MURs replaces Skills for the Future. Students using this course for MUR accreditation must submit their work for assessment by the end of 2009.

Skills for MURs is supported by an educational grant from GSK Plus. **EW**

Flu communication not good enough, says Mason

But calls for greater central planning rejected by pharmacy tsar

Jennifer Richardson

Some PCTs have not been sufficiently involving or communicating with community pharmacy during the swine flu outbreak, the Department of Health's community pharmacy tsar has said.

Communication with the sector "could have been done better" by some trusts, Jonathan Mason told C+D. He admitted: "We're aware it wasn't conducted quite as well as it could have been initially."

But the national clinical director for primary care and community pharmacy rejected calls for a more centralised approach to pandemic planning. "It has to be local action," Mr Mason insisted. Instead, he said, better performance management of PCTs' adherence to DH guidance was needed.

"The national guidance has been very clear [that pharmacy should be involved]," he said. "It's just been maybe not interpreted as well as we would have liked at PCT level."

Jonathan Mason: action should be local

Mr Mason and his hospital pharmacy colleague Martin Stephens were working to solve the variability of PCT connections with pharmacy, he said, by improving strategic health authorities' benchmarking of trusts.

Mr Mason's comments came after Lloydspharmacy followed PSNC in calling for greater central co-ordination of pandemic planning.

Lloydspharmacy pharmacy relations and governance director Andy Murdock told C+D the "diversity" of PCTs' plans had presented a "challenge" for the multiple in delivering its response. "I believe it would be more efficient if there was a more centralised approach," he said.

Mr Mason shared frustrations over "a very mixed picture across the country" of pharmacy's inclusion in PCTs' pandemic responses. The variability was "pretty much unacceptable", he said.

Four-strong pharmacy chain Angel Pharmacies has signalled its intention to think big by holding its first staff conference. It comes after a year of appointing new management and rebranding the Weymouth-based company, managing director Dipan Shah told C+D. Building NHS business, and maximising retail sales and services income were among the themes discussed at the Portland Spa and Conference Centre. There was even a motivational speaker at the event (left), which received sponsorship from GSK and Pfizer. "Even a single shop should put some time aside to bring the team together, share its vision and agree the action plan for the year ahead," said Mr Shah. EW

Commissioning promotion

The leading pharmacy bodies have promoted pharmacy's potential to primary care staff, with two publications aimed at increasing the sector's inclusion in commissioning.

The 'Maximising health gains through community pharmacy' documents seek to influence both the commissioning of pharmacy services by PCTs, and the integration of pharmacy into practice-based commissioning.

The documents were launched to PCTs and strategic health authorities (SHAs) by five pharmacy bodies (RPSGB, CCA, AIMp, NPA, PSNC) in collaboration with NHS Alliance.

They give a provider perspective on commissioning and form part of a strategy to promote pharmacists' role to commissioners, managers, GPs and others in primary care. **ZS**

Scotland to consult on pharmacy applications

The Scottish Government has announced a formal consultation on pharmacy contract applications, amid continuing concerns over dispensing doctor arrangements.

The autumn consultation was announced by public health minister Shona Robison last week, in response to questions from MPs.

She said: "The process [to review the applications framework] will begin prior to the summer through discussion and scoping work with stakeholders, with a view to a formal consultation being published in the autumn."

Community Pharmacy Scotland (CPS) was not worried about the potential impact on pharmacy, said chief executive Harry McQuillan. "I don't think this should be anything of real concern," he said. "When it goes to consultations, most people automatically assume that's a bad thing. This need not be."

CPS was "wholly supportive of pharmacies in areas where the population would support the pharmacy," Mr McQuillan added.

Ms Robison's comments follow an amendment lodged by Conservative John Lamont, in support of British Medical Association calls earlier this month for a review of pharmacy applications in Scotland (C+D, May 9, p10). **CC**

Are you ready for the hayfever season?

PRESCRIBING INFORMATION
Fexofenadine Hydrochloride
Tetfast 120mg film-coated tablets
Presentations:
The tablets are film-coated peach coloured tablets containing 120 mg fexofenadine hydrochloride, equivalent to 112 mg of fexofenadine
Indications:
For relief of symptoms associated with seasonal allergic rhinitis
Dosage & Administration:
For the treatment of seasonal allergic rhinitis in adults and children aged 12 years and over, the recommended dose of fexofenadine hydrochloride is 120 mg once daily before a meal. The efficacy and safety of fexofenadine hydrochloride has not been established in children under 6 years of age

Contra-indications:
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Precautions:
Studies in adults have shown that it is not necessary to adjust the dose of fexofenadine hydrochloride in the elderly or in renally or hepatically impaired patients. However, fexofenadine should be administered with care in these special groups
Side effects (Please refer to the Summary of Product Characteristics for full side-effect details):
In controlled clinical trials the incidence of commonly reported adverse events observed with fexofenadine was similar to that observed with placebo. These adverse events were headache, drowsiness, nausea, dizziness, and sleep disorders or paronitia, such as nightmares.
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Fexofenadine is not recommended in pregnancy or for mothers breast-feeding their babies, due to absence of experience in this group of patients
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Marketing Authorisation Number: PL 04425/0157
NHS Price: Pack of 30 Tablets £6.23
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Date of Revision of Prescribing Information: April 2009

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Adverse events should also be reported to Winthrop Pharmaceutical UK Ltd as follows:- Email: uk-drugsafety@sanofi-aventis.com Tel. 01483 554242 Fax.:01483 554806

For further information please visit our website www.winthrop-pharma.co.uk, freephone 0800 854431 or contact Winthrop Pharmaceuticals, 1 Onslow Street, Guildford, Surrey, GU1 4YS. Fax number 01483 554831. Date of Preparation April 2009. STW 374

Dispensary talk

Does homeopathy have a place in pharmacy?

"I'm not really a believer myself, I'm a bit sceptical. But there are people who swear by it. So if it's not doing them any harm and it makes them feel better then I don't think it should be a problem."
Lorraine Moore, Rowlands Pharmacy, Sunderland

"It does. I've been practising for 30 years and I have not sold a lot but I have done some. In certain areas where I've worked there has been a lot of demand for it. It works for the patients."
Dilip Patel, Mirage Pharmacy, Birmingham

Web verdict

Yes 44%

No 56%

Armchair view: To some it's a valid treatment while others see it as pure snake oil. The issue remains divisive, with just under half agreeing that homeopathy has a home in pharmacy.
Next week's question: Has your primary care body kept you informed about plans to manage an outbreak of swine flu? Vote at **www.chemistanddruggist.co.uk**

New professional body input is a 'public duty'

Not to be involved would be "professional mistake", says Clarke

Jennifer Richardson

It is pharmacists' public duty to contribute to the development of the new professional body. Not to do so would be a "professional mistake", the leader of its steering group has warned.

Transitional Committee chairman Nigel Clarke made a "plea for involvement" at the RPSGB's AGM last week. He said: "Anyone who shrugs their shoulders and says it's not for me would be making a categorical professional mistake, I would suggest, and it's their public duty to do so."

Mr Clarke directed Society members to the Commitment to Pharmacy website for the leadership body, www.pharmacyplb.com, which now includes a five minute guide to the organisation. "There will be continued engagement with pharmacists but the success of that depends on all pharmacists being prepared to be engaged," he said.

Nigel Clarke: plea for involvement

One AGM attendee said the proposed national board structure of the body was "trying to run before you can walk". The representative was worried such an ambitious devolved structure could cause the body to "go bust" if there was not enough membership support.

But Mr Clarke said the model was based on member consultation and "relevant to the world in which the profession works". He added: "If you go around saying only 10 per cent of the profession's going to join, you'll fulfil your own prophecy."

The leadership body must do more to improve and apply the science and research base of pharmacy, Mr Clarke also argued.

He said: "The key thing is about how the new professional body gets smart about spending more money on research without bankrupting individual pharmacists in the process."

£200k to cut backlog

The RPSGB has pledged to reduce the "unreasonable" amount of time pharmacists have to wait for disciplinary hearings.

The Society would spend an extra £200,000 for the Disciplinary Committee to sit for more days in 2009, outgoing treasurer Andrew Gush revealed at the AGM last week. He said: "We recognise unreasonable delays to the hearing of cases causes considerable stress to the members involved. This is not acceptable."

Increased delays before cases were heard had been caused by the "extra complexities" of the Pharmacists and Pharmacy Technicians Order 2007, Mr Gush said.

The money was intended to allow the Society to hand over regulation to the General Pharmaceutical Council without a backlog.

"We will pressurise the new regulator to maintain this position," Mr Gush said. He added: "The days of waiting months... to be judged by the regulator must come to an end."

The extra £200,000 would be managed within existing budget levels, Mr Gush said. **JR**

Society anticipates job losses

The Society anticipates redundancies when it loses its regulatory role and forms a new professional body, its financial director has said.

Potential staff losses could occur as a result of the new leadership body concentrating on "very clearly member-focused activities", said Bernard Kelly at the RPSGB AGM.

No redundancies of regulatory staff transferring to the new regulator, the General Pharmaceutical Council (GPhC), were foreseen, he said. Any job losses here would be the GPhC's responsibility.

But in anticipation of redundancies among those who remained with the professional body, Mr Kelly said, the Society had replaced staff departing from at risk positions with flexible or fixed term contracts.

The Society's argument that any pension deficit attributable to staff departing for the GPhC should not be left with the professional body seemed to be "bearing fruit" with the DH, he added. **JR**

AGM bites

Order response on way

Westminster and the Scottish Government are expected to publish their consultation response to the draft Pharmacy Order 2009 in early June, England's chief pharmaceutical officer Keith Ridge said. The Order will establish the profession's future regulator, the General Pharmaceutical Council (GPhC), which is due to take over the RPSGB's regulatory role in spring next year.

GPhC on target

The recruitment of the chair and council of the GPhC is "well underway", England's chief pharmaceutical officer Keith Ridge said. Interviews for the chair were scheduled to take place next week, on June 4, and all Council members are expected to be in post by the autumn. He said: "Not withstanding a general election, we are still on target for delivery in the spring of next year."

New body needs new minds

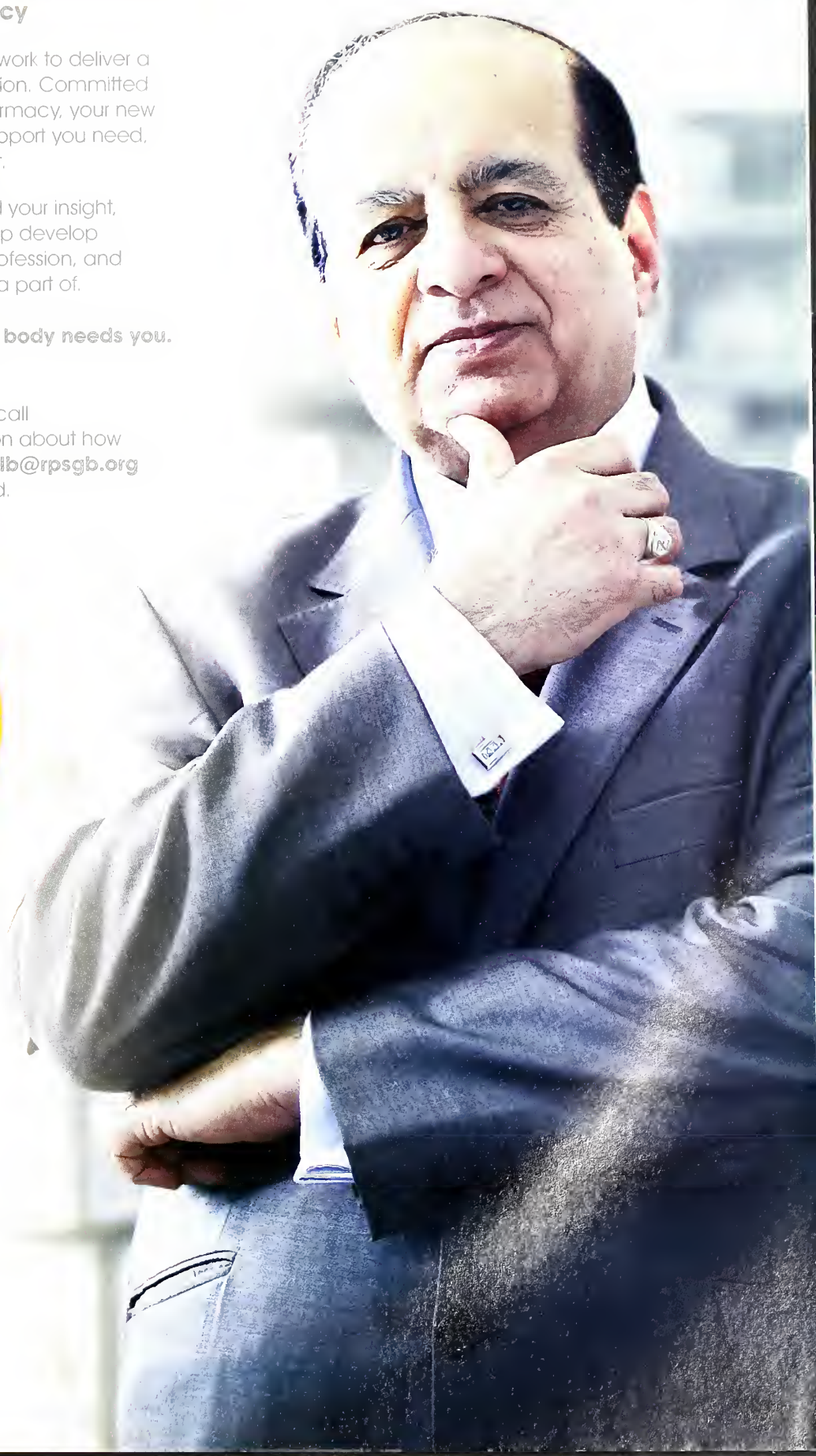
Help us build an exciting new professional leadership body for pharmacy

This is an exciting time for us, as we work to deliver a new leadership body for the profession. Committed to being the influential voice of pharmacy, your new body will focus on giving you the support you need, whenever and wherever you need it.

But we can't do this alone. We need your insight, knowledge and commitment to help develop a unified, positive and energised profession, and a future we can all be proud to be a part of.

Your new professional leadership body needs you.

Visit the newly launched website at **www.pharmacypib.com** today or call **0808 168 5141** for more information about how to get involved or email us at **newpib@rpsgb.org** and let us know what's on your mind.



RPSGB is working with the profession to build a new professional leadership body for pharmacy

www.pharmacypib.com

New formula for Imigran Recovery

GSK has introduced a new formulation for Imigran Recovery – an OTC sumatriptan for migraine sufferers.

The lactose-free formula is designed to allow rapid release and early absorption into the bloodstream. It will help migraine sufferers to return to their daily activities within one hour, says GSK.

The product should only be recommended after completion of GSK's migraine questionnaire and a new trigger diary is available to provide pharmacists with an additional tool to help counsel customers.

The diary invites the migraine sufferer to log their migraine activity, warning signs and symptoms to gain a clearer picture of their migraine. The results can then be discussed as part of their

migraine management. Copies of the diary are free while stocks last.

Price: £7.82/2 x 50mg tablets
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.MyPharmAssist.co.uk

Get plastered with Ice Age 3 assortment

Beiersdorf has teamed up with 20th Century Fox to launch Elastoplast Ice Age 3 plasters to tie in with the new Disney Pixar blockbuster film this summer.

The Elastoplast Ice Age 3 pack contains 16 assorted water-resistant plasters that are printed with images of Ice Age 3 characters including Sid, Scrat, Diego and Manny.

In conjunction with St John Ambulance, Beiersdorf has launched a campaign to encourage parents to learn basic life-saving first aid skills and prepare for accidents in the home.

Easy-to-read factsheets offer potentially life-saving advice to parents on how to deliver emergency first aid for children in numerous situations – from cuts and nosebleeds to unconsciousness and hypothermia.

They are available to download at www.elastoplast.co.uk.

Price and Pip code: £2.49/16 plasters, 345-0871
Beiersdorf
Tel: 0121 329 8800

Hermesetas distributor

Hermes Sweeteners has appointed Ceuta Healthcare to handle sales and distribution of the Hermesetas range of table top sweeteners. Pharmacies with an Unidrug Distribution Group (UDG) account should contact the company directly to place orders. Other pharmacies should contact Ceuta Healthcare.
UDG; tel: 01773 510123
Ceuta Healthcare
Tel: 01202 780558

Corsodyl campaign raises gum awareness

Corsodyl will be back on TV from early June until mid July as part of GSK's £3.4 million support package for the brand this year.

The 'Gorgeous' TV advertisement focuses on Corsodyl Mint Mouthwash, but will also feature the new Daily Gum & Tooth Paste.

The TV ad will be reinforced by a campaign in national newspapers and magazines that features hard-hitting facts and figures about gum disease. Readers are directed to www.gumsmart.co.uk, which helps consumers to understand the causes, symptoms and treatment of gum disease and how to maintain healthy gums.

An online campaign for healthy gums is due to go live on the website in June when visitors will be invited to take up a 21-day challenge that will act as a launch platform for Corsodyl Daily Gum & Tooth Paste.

GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637
www.MyPharmAssist.co.uk

Summer promotion gives 42pc profit on return

Ratiopharm is promoting its new Life's-Biotic probiotic food supplement via AAH Pharmaceuticals, Phoenix, Numark and Alliance Healthcare in June. The promotion covers all three formats – drinkable liquid vials, drinkable powder sachets and capsules. The initiative is set to enable a 42 per cent profit on return for pharmacists, said Ratiopharm.

From June until August, pharmacy sales will be supported by a £500,000 marketing campaign.

The website www.lifes-biotic.co.uk offers downloadable information for consumers and health professionals.

Ratiopharm; tel: 02392 386199

Alldays is now Always

Procter & Gamble has rebranded its Alldays liner range, making it part of the Always brand. New packaging communicates the 'new name, same Alldays product' message.

The range has also been extended with two individually wrapped liner variants. The individually wrapped liner segment represents 24 per cent of the overall liner market (IRI 52 w/e Dec '08) and P&G aims to boost growth by driving daily usage.

A TV and print advertising campaign starts in July.

Procter & Gamble
Tel: 0800 597 3388

Benadryl ALLERGY RELIEF

On TV next week

Benadryl Allergy Relief: All areas
Bimuno: STV, G
Clarityn: All areas
Compeed Blister Plasters: All areas except GMTV
DulcoEase: GMTV, Sat
Haymax: ITV
Levonelle One Step: All areas
Merial Frontline Spot On: GMTV, Sat, five, C4
Touch of Grey: All areas
PharmaSite for next week: Lipobind – windows, **Lipobind** – in-store, **Lipobind** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Retail talk

How do you think your sales of holiday health products will fare if more people take UK holidays this year?

Better than usual 0%

Worse than usual 83%

No different to usual 17%

Off the shelf view:
Not much general optimism for your holiday health sales, with fewer customers likely to be stocking up for foreign climates, although pharmacies in British coastal resorts can look on the bright side – if we do have good weather this summer, they should do better than usual!

This week's question:
Is swine flu panic-buying still having an impact on your sales of hand sanitiser? Vote at **www.chemistanddruggist.co.uk/prodnews**

Homeopathy: just where do you stand?

Homeopathy has been around for over 200 years and, however much pharmacists and medics bang on about randomised controlled trials and the scandalous quackery of complementary medicine, it is in all probability likely to be around for many more years to come. And the latest news that the MHRA has granted Nelsons the right to label one of its arnica products with its intended use (C+D, May 23, p6) has just stirred the debate even further.

The move follows the introduction of the National Rules Scheme in 2006, which permits indications for such products to be limited to the relief of minor symptoms or minor conditions. And, according to the MHRA, the new scheme addresses the inconsistencies in the way that homeopathic products were marketed in the UK to create a level playing field.

Now nobody can deny homeopathy exists and I admit that like most pharmacies I sell a limited range without promoting its benefits. But the trouble is, I don't know much about the remedies, so if the products are labelled with indications, it will not only give me more information but also the people who choose to buy them.

It's a universal truth that if members of the general public swear by their complementary therapy, then it's going to be pretty difficult to dissuade them otherwise. And if the National Rules Scheme can provide some clarity about what a product is for, then it's got to be better than nothing. And despite constant attacks from proponents of conventional medicine, around 100,000 physicians across the world now practise homeopathy, and sales of its remedies are worth over £1 billion.

And surely pharmacists arguing against homeopathy must be aware of the obvious chink in their armour – that some OTC medicines could be proved less effective than we thought if subjected to randomised controlled trials. I don't hear anyone calling for these products to be outlawed.

So I disagree with the Slough & District branch motion at last week's RPSGB Branch Representatives meeting that registration as a pharmacist and practice as a homeopath is incompatible. There are more important issues at stake for community pharmacy than this and that's where we should be focusing our energies.

Where does the buck stop for locums?

Talking to a group of community pharmacists at a recent branch meeting demonstrated to me the complete paranoia that has gripped the profession since the Elizabeth Lee case. Everyone appears to be absolutely terrified of making a dispensing error and the consequences of it.

Many agreed that their working conditions were so pressurised and dreadful that errors were bound to occur, particularly by elderly pharmacists or newly qualifieds thrown into the maelstrom of a busy dispensary in an understaffed pharmacy. A couple of locums spoke of their unwillingness to work again at certain pharmacies or for certain companies and I now find myself declining some bookings. I welcome the steps taken by the PDA as an appropriate response and the whole matter will doubtless rumble on for a considerable while yet.

A few weeks ago, I worked for the first time in a local pharmacy that was ridiculously busy. I walked in to find the place packed with pensioners all clutching their green forms. The dispensing bench was covered with trays from the previous day, waiting for me to check and initial them. The first tray I picked up had four boxes of citalopram 20mg labelled enalapril 20mg. Good start, I thought: a few minutes later a box of pantoprazole 40mg labelled 20mg. Then three boxes of Insulin Humulin labelled Mixtard 30. I looked at the shelves full of already dispensed prescriptions. Was I responsible for those as well or just the ones that I dispensed, checked and initialled? Where does the buck start and stop? What is the attitude of area managers and locum boards to locum errors? Will all dispensing errors, however minor, soon have to be reported to the local PCT or the Society? Will error logs become a thing of the past as pharmacists refuse to incriminate themselves or their colleagues?

> "A COUPLE OF LOCUMS SPOKE OF THEIR UNWILLINGNESS TO WORK AGAIN AT CERTAIN PHARMACIES"

But it isn't all so bad, to be fair. Recently, I assisted two excellent newly qualified pharmacy managers who were terrific and quite put me to shame. Their competence and enthusiasm was appreciated by the staff and there was a happy atmosphere. Both pharmacies were very busy, had long established staff who got on well and welcomed me with open arms (well, nearly). I cannot wait to return.

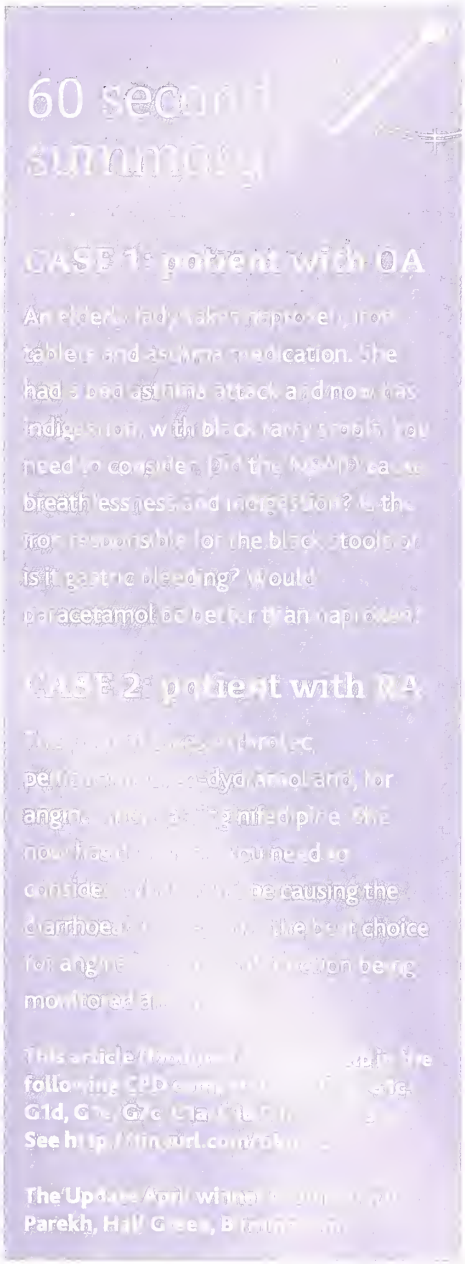
30.05.09

Features

Update

MUR case studies

Case 1: How do you treat a patient with OA and worsening asthma?
Case 2: How do you treat a patient with RA suffering weight loss?



Supported by
GENUS PHARMACEUTICALS

Chinjal Patel MRPharmS

The following two cases studies highlight the issues a pharmacist should consider when reviewing medication for a patient with osteoarthritis and asthma, and another with rheumatoid arthritis and angina.

Osteoarthritis

Osteoarthritis presents as pain and stiffness in the joints, especially first thing in the morning. Commonly, the affected joints are swollen and inflamed, and typically there is limitation in their mobility. Presentation can vary from mild to debilitating and normally exhibits flare-ups with periods of remission.

Non-drug measures such as exercise and weight loss (in those who are overweight) should be recommended initially and continued in management of the condition. For pain relief, Nice advises paracetamol should be tried first. Topical NSAIDs and/or paracetamol should be tried ahead of oral NSAIDs, Cox-2 inhibitors or corticosteroids

CASE 1: Mrs Davies

Mrs Davies is a slim, 74-year-old regular customer. She suffered a bad asthma attack and has been in hospital for a couple of weeks. Recently she has been experiencing severe heartburn and indigestion, which has reduced her appetite.

She has come in today with the following prescription: Uniphyllin 400mg 1 bd, Gaviscon Advance 10ml tds prn. She asks if any of her medicines could cause indigestion. You look at her PMR and notice she is on naproxen, which could be causing or contributing to her symptoms. She is also on asthma medication and you feel she would benefit from an MUR.

Mrs Davies' PMR shows:

- salbutamol 100mcg cfc-free inhaler 2 puffs qds prn
- beclometasone 200mcg inhaler 2 puffs bd
- salmeterol cfc-free 25mcg inhaler 2-4 puffs bd
- ferrous sulphate 200mg 1 tds
- metoclopramide 10mg 1 tds prn
- naproxen e/c 500mg 1 prn

Mrs Davies tells you she had suffered a bad flare-up of her osteoarthritis with the recent cold weather. She had severe knee pain and was struggling when taking her dog for walks. She has also noticed black stools recently and says she was informed that this may be a side effect of her iron tablets.

She confesses she smokes up to five cigarettes a day and has attempted to quit many times. The only other medication she takes is multivitamin capsules bought OTC.

Initial points to consider

- Could any of Mrs Davies' medicines be causing her indigestion?
- Could any contribute to her asthma?
- Has Mrs Davies been titrated up to Uniphyllin 400mg bd? (It's too high for a starting dose).

Looking at the medication

Osteoarthritis (naproxen)

- Paracetamol or ibuprofen alone may be adequate or they may be used together. Have these already been tried?
- Did the naproxen cause the breathlessness or the indigestion, or both?
- Could the dark stools be the result of a gastric bleed caused by the naproxen? Could that further explain the anaemia?
- Can the naproxen be changed to something safer?

Asthma (salbutamol, beclometasone, salmeterol, theophylline)

- What caused the asthma attack? Was it worsening of the asthma, or the naproxen?
- Check Mrs Davies' inhaler technique.
- The patient is now on step 3 of the BTS guidelines on asthma management. Has asthma control been OK since she left the hospital? Was the attack a one-off or is her asthma deteriorating? Is there a possibility of any dose reduction in the medication?

Iron-deficiency anaemia (ferrous sulphate)

- What caused the anaemia? Did the naproxen cause a gastric bleed, which might explain the black stools?

Indigestion (Gaviscon Advance)

- What caused the indigestion – the naproxen or the Uniphyllin?

The MUR

Mrs Davies seems quite knowledgeable about her medicines and has good inhaler technique. You ask if she has had the Uniphyllin before; she says it was prescribed in hospital and is now on a higher dose. She takes the naproxen for her osteoarthritis but hardly ever needed it until a recent flare-up forced her to take up to two tablets daily. Questioning reveals she has not tried paracetamol. She was prescribed metoclopramide for a bout of nausea a while ago but does not need it any more. She had some blood tests done at her GP's surgery last week but can't remember what they were.

Would you suggest any medication changes?

Naproxen According to Nice guidelines, paracetamol should be tried first in osteoarthritis and then a topical NSAID. You could, therefore, suggest the GP changes the naproxen to something safer or prescribes a proton pump inhibitor in addition.

Asthma medication This needs to be reviewed.

Metoclopramide You could mention to the GP that Mrs Davies says she no longer needs this, to avoid unnecessary prescribing.

Other issues

- Mrs Davies smokes. Plasma theophylline levels are reduced in smokers.
- Theophylline needs monitoring.
- Theophylline plus inhaled salbutamol can increase the risk of hypokalaemia.
- Was the last blood test for checking plasma theophylline? Or iron level?

Discussion with the GP

You contact Mrs Davies' GP and express your concern regarding the naproxen being a possible culprit for the indigestion and that it isn't a first-line recommendation for osteoarthritis. You mention your further concern of Mrs Davies' black stools, which could be the result of an ulcer. The GP agrees with you and asks you to refer her back to the surgery. You send him a copy of the MUR.

Counselling points

- You could encourage Mrs Davies to stop smoking as this can aggravate asthma and decrease theophylline levels. Discuss NRT options available.
- Ensure Mrs Davies is having tests for renal function, blood iron and potassium levels.

Rheumatoid arthritis

Rheumatoid arthritis can affect the whole body, including the heart, lungs and eyes. Treatment includes analgesics, NSAIDs and disease modifying anti-rheumatic drugs (DMARDs). DMARDs suppress inflammation to slow down disease progression. The earlier the treatment is started, the less joint damage is likely. Surgery is needed in some cases if a joint becomes badly damaged.

CASE 2: Mrs Prentiss

Mrs Prentiss comes in with her regular repeat prescription and a new item prescribed today – loperamide capsules. The medicines are:

- Arthrotec 50 (diclofenac, misoprostol) tabs 1 tds
- penicillamine tabs 250mg 1 bd
- co-dydramol tabs 2 qds
- nifedipine 10mg caps 1 tds
- ferrous sulphate 200mg tabs 1 bd
- loperamide 2mg caps take as directed

Mrs Prentiss mentions she has lost a lot of weight with a recent bout of diarrhoea. Her PMR also shows recent supply of:

- lactulose solution 15ml bd
- Nitrolingual pumpspray 400mcg as directed.

Initial points to consider

- What could have caused the diarrhoea? The Arthrotec, nifedipine or ferrous sulphate?
- Have other NSAIDs already been tried? (Nice advises that when an NSAID is prescribed in RA, a proton-pump inhibitor should be co-prescribed).
- Is Mrs Prentiss still taking the lactulose? Was there a recent overuse?
- Does she know how to take the loperamide?

Looking at the medication

Rheumatoid arthritis (Arthrotec, penicillamine, co-dydramol)

- Arthrotec can cause diarrhoea.
- Penicillamine requires blood counts, including platelets, and urine examinations every four weeks. It can cause mild renal impairment, hence the need to monitor.
- The diclofenac in Arthrotec can cause mild renal impairment.
- The patient is taking the maximum dose of co-dydramol, which can lead to moderate to severe renal impairment.
- There is an increased risk of nephrotoxicity when penicillamine is given with NSAIDs. Would a topical NSAID be better?

Angina (nifedipine, Nitrolingual spray)

- Why is the patient on short-acting nifedipine? It is not recommended in the BNF.

Iron-deficiency anaemia (ferrous sulphate)

- What caused the iron deficiency? Is there a lack of iron in the patient's diet? Has she lost her appetite as a side effect of penicillamine?

Constipation (lactulose)

- What caused the constipation – the ferrous sulphate or nifedipine?
- Is Mrs Prentiss still taking the lactulose?

Diarrhoea (loperamide)

- What caused the diarrhoea – the ferrous sulphate, the misoprostol in Arthrotec, lactulose or nifedipine?

The MUR

Mrs Prentiss is knowledgeable about her medicines but is confused why she takes nifedipine. She thinks it's for high blood pressure and mentions her recent BP reading was 126/82mmHg. She has had arthritis for about three years and has been on Arthrotec for four months. The preceding NSAID prescribed was diclofenac alone. You ask about the ferrous sulphate; she says she is a vegetarian, doesn't have an iron-rich diet and has always had low iron levels. She confirms her GP has explained the dosage regime of the loperamide and she rarely takes the lactulose.

Would you suggest any medication changes?

Arthrotec Advise GP to review. You could suggest an NSAID with a PPI instead.

Nifedipine Advise GP to review and suggest a modified-release preparation, prescribed by brand name. The BNF says short-acting nifedipine preparations are not recommended for angina prophylaxis. This is because nifedipine has more influence on vessels than the myocardium, so short-acting preparations may be associated with large variations in blood pressure.

Lactulose Advise GP to review.

Discussion with the GP

You contact Mrs Prentiss's GP and express your concern regarding the Arthrotec being a likely cause of the diarrhoea. You make your alternative suggestions for nifedipine. The GP confirms the nifedipine was initiated for angina, but will be reviewing this with the RA review that she is due this week.

Counselling points

- Penicillamine causes increased risk of nephrotoxicity when given with NSAIDs – ensure renal function tests are carried out.
- Absorption of penicillamine is reduced by oral iron, so advise taking at least two hours apart.
- Do not take grapefruit juice with nifedipine.
- You inform Mrs Prentiss that her GP wants to review some of her medication.
- You advise Mrs Prentiss to increase her fluid intake to prevent any dehydration.

Chinjal Patel MRPharmS, PG Dip, is a community pharmacist in Oadby, Leicester.

NEXT WEEK'S UPDATE

The causes and complications of cystic fibrosis and its management.

MUR case studies

Which pain relief should be tried first for osteoarthritis? What are the risks of prescribing theophylline and inhaled salbutamol together? What should be monitored in patients on penicillamine?

This article uses case studies to present useful information for carrying out MURs in patients with osteo and rheumatoid arthritis.

Update your knowledge of OA from the Patient UK website at **www.patient.co.uk/showdoc/40001173.**

Read the Nice quick reference guide to OA at **http://tinyurl.com/d633rn** and print out the flow chart for assessment, management and treatment if you think it may be useful when carrying out MURs.

Look at the Patient UK website to revise your knowledge of RA at **www.patient.co.uk/showdoc/40025263** and disease modifying anti-rheumatic drugs at **www.patient.co.uk/showdoc/40024874.**

Revise the stepwise management of asthma in the BNF Section 3, Respiratory System.

Revise the BNF sections on drugs used in OA and RA.

Read MUR tips for RA and angina in the C+D MUR Zone: **www.chemistanddruggist.co.uk/tipsbycondition**.

Are you now aware how drugs used to manage OA and RA may cause problems? Do you know how asthma and angina drugs may complicate treatment? Do you feel confident about giving advice during an MUR?

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Step 2

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Step 3

Use your PIN to complete the assessment online or phone through your answers. Your test score will be recorded. If you successfully complete the 5 Minute Test online, you will also be able to download an RPSGB-approved CPD certificate

Registering for Update 2009 costs £32.50 (inc VAT) and can be done easily at www.chemistanddruggist.co.uk/update or by calling 01732 377269. Signing up also ensures that C+D's weekly Update article is delivered directly to your inbox free every week with C+D's email newsletter.

Get an RPSGB-approved CPD certificate for your portfolio when you successfully complete the 5 Minute Test online

Practical Approach

Antihistamines for a horse

> IF YOU DON'T LET ME HAVE THOSE TABLETS I'LL JUST TAKE MY BUSINESS SOMEWHERE ELSE

Salma Hussain, formerly pre-registration pharmacist trainee at the Update Pharmacy and currently working as a locum, is working in a pharmacy close to a riding stables. Salma is at the medicines counter one afternoon when a woman comes in.

"Hello dear," the woman says, "you're new here, aren't you?"

Salma explains that she is the locum pharmacist.

"Nice to meet you," the woman continues. "I'm the owner of the stables. I've just come in for some more of those antihistamines I get for my horses if they get itchy."

Salma asks: "Have you had them here before?"

"Oh yes, several times. I can't remember what they're called but they're not the ones that cause drowsiness – can't have my horses nodding off on the job, can we? Go and ask Carole there what they are."

Salma goes over to assistant Carole and asks her. Carole says they are cetirizine tablets. Salma goes back to the woman and says: "I'm afraid I can't sell you these for your horses."

The woman retorts: "What are you talking about? I get them here all the time. The vet recommended them. I told that to the regular pharmacist the first time I came in and he's always sold them to me. You're not telling me that the vet and the other pharmacist don't know their jobs! I do a lot of business here; if you don't let me have those tablets I'll just take my business somewhere else!"

Questions

1. Was Salma correct? What is the legal position?
2. The stable owner went away happy. What did Salma do?

Answers

1. Cetirizine may not be sold over the counter for an animal. Although cetirizine can be sold without prescription for human use, it is not licensed for animal use and if for use for an animal it becomes a POM-V, which can only be supplied against a written prescription from a veterinary practitioner. As it is not licensed for animal use, the vet must go through the 'cascade' process before prescribing it, ie he or she must assure him or herself that there is no animal medicine available, licensed either for the same indication in another animal species or for another condition in the same species. The pharmacist should be satisfied that the 'cascade' process has been gone through.

2. Salma contacted the vet who had suggested cetirizine to the stable owner, but was unaware of the need for a written prescription in this case. She was grateful for the advice and issued a repeatable prescription, which Salma dispensed. Salma also left a note for the regular pharmacist, advising him of the need for a written prescription in this situation.

This article can help with the following CPD competencies: G1h, G2a, G2k, G4a.
See http://tinyurl.com/68ox7b

Ethical dilemma

What to do if you suspect a child has been abused

This series aims to help you make the right decisions when confronted by an ethical dilemma. Every month we present a scenario likely to arise in a community pharmacy and ask a member of the Pharmacy Law and Ethics Association (PLEA) to comment on the legal and ethical implications of the actions open to you. Readers are invited to have their say at **ethics@cmpmedica.com**

When it comes to child safety and protection, doing nothing is not a valid option. Although, under normal circumstances, patient confidentiality must be maintained and consent is required before you disclose information to a third party, there are exceptional circumstances. However, before disclosing information without consent you must be prepared to justify your decision and any actions you take.

The issues are:

- responsibility to your patient and the children
- implications for the children if you do nothing
- your duty of care
- the child's welfare
- confidentiality.

The RPSGB's Code of Ethics states that "from time to time you may be faced with conflicting professional obligations and legal requirements. In these circumstances you must consider fully the options available to you, evaluate the risks and benefits associated with the possible courses of action and determine what is most appropriate in the interests of patients and public".

The Code's first principle is that you must make the care of patients your first concern, and that you must take steps to safeguard patient wellbeing, particularly children and other vulnerable adults. The Society's professional standard for the release of information in such circumstances states: "Where abuse or neglect of a person is suspected, that person's wellbeing is of utmost importance and ensuring this must be your prime concern."

The RPSGB published comprehensive guidance on child protection in 2005.[1] More recently an article on the lessons to be learned from the Baby P case reaffirmed the important role that pharmacists and pharmacy technicians have in relation to child protection.[2] In January 2009 the National Pharmacy Association publication 'In Touch' reminded members that, although patient confidentiality must be maintained and that consent is usually required before disclosure of information, one of the exceptional circumstances is child protection. Indeed there is a legal obligation to "safeguard and promote the welfare of children".[3]

The Children Act 1989 and the Children (Scotland) Act 1995 lay down the duties of local authorities to work together to safeguard and support the welfare of children. Information about local child protection guidelines and contact details can be obtained from primary care organisations.

What action should be taken?

- Seek advice from your local professional with expertise in child protection. Do you know who this is? If not, find out and keep details for future reference.
- Follow local child protection procedures and report your concerns to appropriate authorities. If you don't know who these are, find out and note details for future reference.
- Keep a record of the incident and note your concerns and actions taken.
- Consider completing CPPE or NES Pharmacy Scotland open learning programmes (www.cppe.ac.uk; www.cardiff.ac.uk; www.nes.scot.nhs.uk/pharmacy/courses
- Read – ACMD Report Hidden Harm: Responding to the needs of children of problem drug users. (2003) Chapter 5 pp 58-62, www.drugs.gov.uk

Kay Roberts MPhil, FRPharmS, chair PharMAG

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1. Pharm J, 2005, 275, pp175-178; 2. Pharm J, 2009, 282, p75; 3. InTouch, 2009, 30, p4, NPA.

G1h, G1m, G3a, G4a, G5c, G5d, G7b. See http://tinyurl.com/68ox7b

PLEA is an association of pharmacists interested in law and ethics, and lawyers or ethicists specialising in pharmacy, with the aim of promoting understanding of the ethical basis for professional judgement
www.wingfieldworks.co.uk/plea/index.html

DISPENSING JUSTICE

Patient deaths and the law

What happens if you make a dispensing error and a patient dies? This was the main topic on the agenda at PLEA's latest seminar. **James Clegg** reports

Being implicated in the death of a patient is obviously a nightmare scenario for any pharmacist, both professionally and personally. But the legal consequences could include a custodial sentence. "We thought this topic would be appropriate in light of the introduction of the Corporate Manslaughter Act last year," said committee member Edward Mallinson, as he introduced last week's Pharmacy Law and Ethics Association (PLEA) seminar. "Little did we know, when we arranged it, there would be a judgement that would mean far more scrutiny on safety in our profession."

The judgement in question is, of course, the case of locum Elizabeth Lee, found guilty under the 1968 Medicines Act following a dispensing error she made while working in a Tesco pharmacy. Despite a coroner ruling the dispensing error was not the cause of death, Ms Lee received a three month suspended sentence.

Last week C+D launched the Dispensing Justice campaign to decriminalise dispensing errors. Until that happens, what is a pharmacist likely to go through if a patient dies? The PLEA seminar brought together four experts to explore different aspects of the issue.

The role of the Coroner

Dr Roy Palmer, Southern District of London Coroner's Court

In England and Wales coroners are independent judicial officers whose duties include investigating deaths of bodies lying in their jurisdiction where the death was violent, unnatural or sudden and with unknown cause. At an inquest, they verify who the deceased was, how, when and where they died, and the particulars needed to register the death. No opinions on any other matter should be expressed, including framing a verdict that appears to decide any question of civil or criminal liability on the part of a named person.

Common verdicts include death by natural causes, accident/misadventure, suicide, a narrative conclusion which is more specific to the case, or an open verdict where there is insufficient evidence to offer another conclusion. Causes of death relating to community pharmacists could involve wrong drugs, wrong patient (common surnames), wrong dose (decimal points, etc), and wrong routes of administration. Common issues may pertain to supervision, checking and labelling, clarity of instructions, paediatric or geriatric doses and drug interactions.

The role of the Procurator Fiscal

Linda Cockburn, Crown Office and Procurator Fiscal's Office

In Scotland, procurator fiscals fulfil the same function as coroners in England and Wales. They are also involved in pursuing prosecution, a role fulfilled by the Crown Prosecution Service south of the border.

Cases to be investigated include deaths under medical care. This covers intervention or lack of intervention that may have had a bearing on the death including medication errors, any death where the next of kin has complained about the medical treatment of the deceased, unexpected deaths in relation to the deceased's clinical condition prior to medical care and fatalities attributable to a therapeutic or diagnostic hazard or apparently associated with a lack of medical care.

Fatal accident inquiries (FAIs) carried out by the procurator fiscals can require NHS staff, including pharmacists, to give a statement, attend for precognition to see if there are grounds for prosecution and speak to other represented parties in the inquiry. Guidance on FAIs is now issued by the NHS for staff involved.

The Corporate Manslaughter Act

Julie Austin, Hempsons Solicitors

The Corporate Manslaughter and Corporate Homicide Act 2007 came into effect in April last year and can apply to pharmacy businesses ranging from national multiples to small independents. Organisations can be found guilty if their activities cause a death where there was a gross breach of relevant duty of care to the deceased. This must be shown to originate at senior management level, defined as being where all or a substantial amount of the company's activities are managed.

Penalties if a company is found guilty could be an unlimited fine, remedial order, or publicity order, where it must publicise details of the case. Individuals within the company cannot be charged with corporate manslaughter but could be charged for the same fatality under separate legislation. Steps that can be taken to guard against prosecution include:

- following guidance from relevant organisations like the DH and Nice and ensuring compliance with Health & Safety Executive regulation
- maintain and enforce risk assessment
- constantly monitor safety standards
- make managers aware of their responsibilities, in terms of both patients and monitoring staff members.

Facing a coroner's inquest

Graham Edwards, pharmacist and barrister

A pharmacist will usually be approached for information, a statement or an interview by other investigators, prior to a coroner's inquest. These could be the RPSGB, an employer, their PCT or the police.

It is advisable to decline to comment without first seeking legal advice. This may conflict with the Society's Code of Ethics (point 7.10 says you must "co-operate with investigations into your or another healthcare professional's fitness to practise") or with contractual obligations to an employer or PCT, but could prevent the pharmacist from saying anything that could later implicate them should the inquest lead to a criminal investigation. In these cases the pharmacist may need to consider whether risking their employment position is more or less serious than the possibility of a custodial sentence or putting their professional registration at risk.

The coroner usually requests a statement in advance of the inquest and it is also important to seek advice before submitting this. If the pharmacist has to attend the inquest they should refresh their memory of the statement beforehand and bear in mind their legal right not to incriminate themselves while answering any questions.

Time to talk about dry mouth?

GSK welcomes Biotène to its oral care family

Approximately 20% of people suffer symptoms of dry mouth[1], primarily related to disease and medication use. More than 400 medicines including tricyclic antidepressants and antihistamines can cause dry mouth[2] and the prevalence is directly related to the total number of drugs taken.[3]

The Biotène patented salivary LP3 enzyme system

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- Helps supplement saliva's natural defences
- Helps supplement saliva's natural antibacterial system - weakened in a dry mouth

biotène® for dry mouth

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Fear of pharmacy

Fact: men are unlikely to visit a pharmacy unless dragged in by their partners. But with more men-specific health services on offer, the male of the species may finally overcome their fear of pharmacy, finds **Emma Wilkinson**

Go into any pharmacy and do a quick gender head count. If you can spot any men (or at least any men under the age of 60) then it must be Saturday and they have been dragged in to the store by their wife or girlfriend.

Most pharmacists probably only see about two men for every 10 people through the door. Yet the boom in male grooming products and the widening of services offered by pharmacy should be attracting the men who traditionally gave the chemist's shop a wide berth. But men still have a very limited insight into what the pharmacist actually does.

Amish Patel, a pharmacist in Longfield, Kent, has been working to try and get more men on the premises but he says it is not an easy job. "It is a problem we are trying to tackle," he remarks. "We have started promoting health checks on a TV screen in the pharmacy and we're also putting leaflets out about the days we're running a men's health clinic. It's difficult because if they're not coming in, how do you tell them about the services?"

Mr Patel says men are becoming more concerned about their health from a fitness point of view. Those that do come in are buying things like multivitamins, with some of the older men even asking for blood pressure checks. The trend has triggered a rethink of the pharmacy's layout, he reveals.

"We have set up a section of men's health products, like vitamins, sort of like they do in Holland and Barrett. You see more and more men going to the gym and talking about getting fit and that's something they are keen on."

The NHS Health Check initiative to check all Britons between the age of 40 and 74 for vascular diseases could be another opportunity to capitalise on men's growing interest in health, according to industry leaders. The scheme, which went live this April, is not only a great way to target killers like heart disease, but can also be used to open men's eyes to wider health issues, says Mimi Lau, director of professional services at Numark.

"Given that heart disease is one of the biggest killers of men, a vascular screening service can play a great part in improving patient outcomes and pharmacists are ideally placed to advise on healthy eating, giving up smoking and exercising," she says.

But Ms Lau says funding from PCTs on vascular checks has not been forthcoming and pharmacists really need to get proactive. "If your PCT hasn't commissioned a service, you need to talk to them urgently. If pharmacy doesn't get in soon they will lose out to other providers, including GPs."

While a wave of David Beckham-inspired grooming may have hogged the headlines in male health, the opportunities for smaller pharmacies to cash in may be restricted. Stephen Foster, of Pierremont Pharmacy in Broadstairs, Kent, says anyone outside the big chains is unlikely to have a big slice of the grooming market. However, offering male-specific health services is where the business is at, he says.

"What we have tried to do is reformat some of the services we offer, so CVD risk assessments we have rebadged as a men's health check and we have had some success with that – we've done hundreds of them. We also have everyday low prices on erectile dysfunction drugs."

Mr Foster says success is down to how you sell the service. For example, call the vascular health checks an MOT – a term men can really identify with – and you could be quids in.

He also recommends advertising services locally, on the website and in the window, to attract men specifically. "We need to make it more comfortable for them – I think if we focus on it the men will come to us," he adds.

10 top tips for [illegible] customers

1. **Rebrand** – MOTs not [illegible]
2. **Advertise** – local papers, [illegible]
3. **In-store promotion** – make [illegible]
4. **Men's health information** – try [illegible] manuals
5. **New services** – try an erectile dysfunction or hair loss service
6. **Keep cool** – don't be too pushy to those that do come in
7. **Window displays** – attract men walking past
8. **Environment** – try not to look and smell like a women's bedroom
9. **Offers** – have promotions on male grooming, vitamins or medicines
10. **Men's health week** – get planning for June 15 to 21

Men's health statistics

£726m The male grooming market is worth £726m in the UK

More than 40% of practising pharmacists are men

80% of men who visit the GP are there at the request of their wife or girlfriend

Only 12.5% of those screened in the 2004-05 NHS Chlamydia programme were male

A recent project by the Men's Health Forum adds weight to the theory. Chairman Ian Banks says: "The idea was to test out the theory that we could get men to use the pharmacy better if you promote it in an area where men talk about health and that's the workplace."

The team carried out a series of focus groups and then produced a leaflet about pharmacy with a voucher in the back for a free men's health check.

"One guy said a pharmacy was all lipsticks and no spanners, but when you ask the pharmacy why they don't have stuff for men they say it's because the men don't come in."

Among the recommendations from the project, which are yet to be published, is that pharmacists provide more for men, such as the Haynes health leaflets that are modelled on the car manuals and can be found at www.menshealthforum.org.uk.

Dr Banks says the key to attracting them is to point out the differences with the GP surgery. "The things that men don't like about going to the GP – that you have to make an appointment and take time off work – don't apply to the pharmacist."

The boy's room

C+D asks three men for their views on pharmacies

Martin Watson, 29, London
"I last went into a pharmacy about 10 minutes ago – hayfever season has officially started and I needed Clarityn. It was fine, pretty empty, although I had to use that daft auto paying thing as a woman was complaining about her photos, which seemed to take all the staff members to resolve."

Jonathan Corrin, 29, Sheffield
"I went in to a pharmacy about six months ago to get some pain relief gel stuff, found it fine, told them what I wanted, she looked me up and down, realised I was unlikely to exceed the recommended dosage and sold me the product. For grooming products, I don't really have any preferences so if a pharmacy was cheapest, I'd go there."

Stephen Hooper, 30, Hull
"I went last week to buy some Echinacea tablets. How often I go would depend on whether I need more vitamins in my diet – so perhaps more easily accessible information on that would be useful. But it is a behavioural thing that men don't seek this info as it is not 'manly'. Women use pharmacies more often and so they cater for them."

A day in the life...

... of Tesco pharmacy services manager Shona Scott

My job is a real mish-mash of activity! I deal with both private services and enhanced services – helping stores set up new services available in that area. It's everything to do with launching a new service, such as marketing materials and training arrangements.

I came into head office on secondment on what was supposed to be a short term basis – but that was 2007 and I'm still here. I was asked to make the move from store pharmacist into head office, but I was looking for a new challenge. I hadn't been qualified very long, but I'd worked in a community pharmacy since I was 17 and was ready for something different.

I started off supporting various projects going on in the office. In particular, we were launching key information leaflets for GP surgeries, so that pharmacists in new stores could take them out and go through the services we do. I worked with the pharmacy team in producing that.

At that time the person in my current role was moving on to another department, so I started to take on parts of the job – and when the person officially left I took on the role full time. I really enjoyed head office so wasn't really tempted to go back into the store, though I do miss the regular customers.

When I first get into work, I check my emails and voicemails and follow them to try to answer all the questions, such as store queries.

We have a new service launching in two months, so today I have gone to a marketing meeting about the look and feel of the new service leaflets and I have given the pharmacy input to that. I have also had a meeting with the training manager, where we discussed the training for the new service. And this afternoon we're going to produce standard operating procedures for the new service.

Shona Scott: Launching a flu vaccination service was one of the highlights

When it comes to a big service like this, launching it will monopolise most of my time, but I always take time for lunch and finish between 5.30pm and 6pm. Then I usually go to the gym – I like exercise. A body combat class is great for stress at the end of the day. I also enjoy spending time with friends and family, and going to the pub – but only my recommended units, of course!

Originally, I wanted to be a maths teacher. I've always been interested in maths and science but I have never had the desire to work in a lab. Then I went to a university open day, and pharmacy just seemed perfect – you get a bit of customer facing as well as the science side. Do I still think it's perfect? It can be – I do very much enjoy it.

The best part of the job is when you see something you've worked on come to fruition. Launching our flu vaccination service is probably the highlight so far. It was a real challenge, so when I saw the first jab being done by a pharmacist in store I had a real sense of achievement. I thought we'd never get there!

I think my least favourite thing is when I come back from holiday and I've got loads of emails. You just click on the inbox and think, "Oh my God!" But day to day there's nothing about it I really don't enjoy. The fact that I'm helping develop services that will change people's lifestyles keeps me going. It's making sure that we get services the pharmacist will enjoy providing and feel proud of, and that patients also need.

Obviously, at Tesco, I do have the opportunity to move into other areas, but I'd definitely like to stay within pharmacy. It's great to see and be a part of pharmacists moving out from behind the dispensing bench to doing services. It's great to be a part of making that happen.

Career tip of the week

"To identify whether you are just suffering from a touch of the blues, put an X in your diary every day you feel unhappy in your job then, after six weeks have elapsed, look back in your diary and add up the total number of times X appears. If the total number is more than half your total working days, perhaps it is time to consider looking for another job." From Brilliant Job Hunting, by Angela Fagan www.chemistanddruggist.co.uk/booksforjobhunters

Career ladder

Two schools of pharmacy boosted their facilities with the opening of model pharmacies this month, as ratings for undergraduate courses appeared in a newspaper league table.

Kingston University unveiled a £420,000 pharmacy practice laboratory with 40 dispensing stations, a counter and consultation area, where students use role-play to practice realistic workplace scenarios.

"It's much more realistic than our old laboratory," said third-year student Roohil Yusuf. "The individual dispensing bays let us practice working independently, which we'll have to do when we get a job."

The University of Portsmouth has opened a model pharmacy with dispensing 'pod' training facility, sponsored by Rowlands Pharmacy.

The eight pods at the university's dispensary each have four work stations. This allows students to work individually and then present findings to the class on wall-mounted screens, which can also be used to show clinical video clips and patient counselling scenarios.

Rowlands managing director Kenny Black said: "Links with universities allow us to be directly involved in undergraduate education and ensure innovation in our business structure."

The University of Portsmouth suffered a blow when it came bottom of the pharmacy courses in The Guardian's University Guide 2010. The University of Strathclyde claimed first place, fighting off stiff opposition from Nottingham and Leeds. The Glasgow university was ranked second overall in the pharmacy and pharmacology category.

The University of Nottingham was ranked second out of pharmacy course providers, followed by the University of Leeds and the University of East Anglia. Queen's University Belfast scored highest in student satisfaction, with 96 per cent of students saying they were happy with the quality of teaching.

Kingston University's new laboratory

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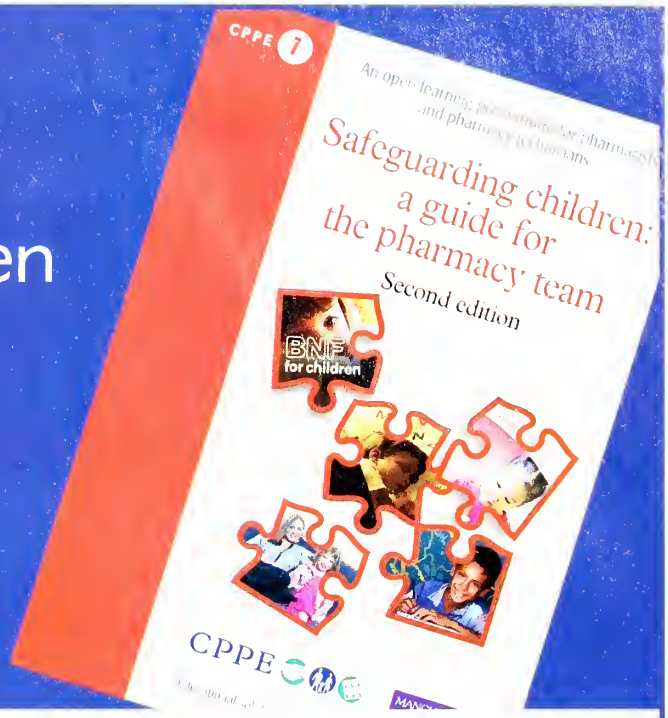

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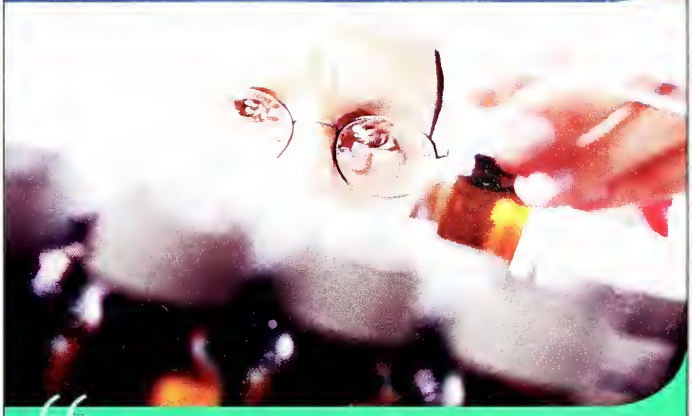

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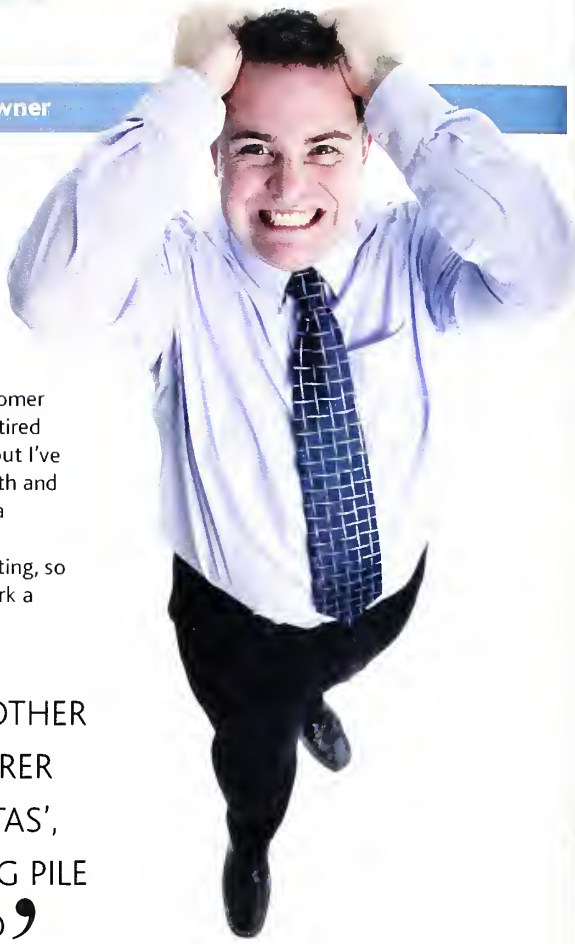
Postscript...

Mike Hewitson's diary of a new pharmacy owner



Supply and reprimand

After nearly six years in practice I was starting to think that I was fairly unflappable. I've dealt with all sorts of situations, kept my cool when others would have 'lost it', and calmed down furious patients, but something has really started to get to me. It isn't very interesting, but it is an issue as serious as anything else facing pharmacists on the front lines – the availability of key medicines.

Why do I spend three hours a week chasing phantom supplies of a number of branded drugs? I blame the French! Well, Europeans in general, if I'm honest. My customers often ask me why I can't give them their life-saving anti-coagulant or their equally important blood pressure medication. "It's all to do with the value of the Euro," I tell them. I feel dull even talking about this at the time, let alone writing about it now, but sooner or later a patient is going to come to serious harm because I and many other pharmacists just cannot get some drugs quickly enough. The stock quota systems that have appeared in recent years just don't appear to be flexible enough to meet rising demand quick enough.

Having endured another week of 'manufacturer imposed supply quotas', and facing a bulging pile of owings, I snapped. The unlucky victim: Wyeth customer services. To their credit they dealt with a tired and sarcastic grouch admirably enough, but I've got to write a letter of complaint to Wyeth and six other companies to bemoan the quota system – when I've got the time!

Until then, our French twin town is visiting, so I'm laying low for now, hoping not to spark a diplomatic incident.

> HAVING ENDURED ANOTHER WEEK OF 'MANUFACTURER IMPOSED SUPPLY QUOTAS', AND FACING A BULGING PILE OF OWINGS, I SNAPPED

Raiders of the lost archives

C+D 1859-2009 Celebrating 150 years in pharmacy

Pharmacists' little helpers took to the fore in the January 1860 issue of C+D, as a "poor, plodding assistant" bemoaned his "15 or 16 hours of incessant toil".

Writing under the pseudonym 'Synovitis', the assistant highlighted the plight of those in his "wretched position", who were paid just 20 shillings a week for their labour.

He wrote: "The working man begins and ends work at 6 o'clock. The assistant begins at 7 and finishes at 10, 11 or even later than that. On Saturday the working man finishes at 2, while the assistant has to toil on till midnight. On Sunday, the working man is at perfect liberty; not so the assistant – he must attend, some all and most the greater part of the day."

Synovitis might feel hard done by, but Postscript takes a different view. If Synovitis had enough time to write letters, he can't have been worked hard enough after all...

Don't try this at home, folks

Postscript will think twice about accepting drinks from strange pharmacists following the gleeful reminisces about Brompton cocktails at the RPSGB Branch Representatives meeting.

What might to the uninitiated sound like a naughty tipple was something more poisonous in nature. The ingredients of the 1920s elixir were heroin, cocaine and alcohol, the idea being to ease the passing of terminally ill patients with pain relief that would also quicken their demise.

Once reportedly used to bump off King George V so his death could be reported by The Times rather than the evening papers, the mixture is now banned. But that didn't stop one branch representative recalling for his audience how, as a teenager whose highest qualification was a swimming badge, he concocted the potion in the back of his dad's pharmacy.

Postscript is getting on a bit now but, from what we do know about teenagers, feel sure that giving them ready access to alcohol and mood-enhancing drugs is asking for trouble...

Ball raises £10k

Aberdeen pharmacists had a ball, literally, to drum up £10,000 for the Archie Foundation for the Royal Aberdeen Children's Hospital.

A total of 160 people descended on the Douglas Hotel in Aberdeen for an evening of dancing organised by husband and wife team Brian and Fiona Arris, pictured, and other pharmacists in their Aberdeen group.

A raffle and charity auction helped to raise £6,000 on the night, which was added to £4,000 raised by the pharmacy group through bingo nights, quizzes, raffles and a charity run.

Brian said: "This was our first large scale charity event and we are very proud of the amount raised for the Archie Foundation. We really appreciate the hard work and effort put in by our colleagues and friends."

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Benchmark is an accredited training course for dispensary assistants. Written by a team of experienced community pharmacists and medical writers, Benchmark has been mapped to both the Pharmacy Services S/NVQ2 and the Skills for Health framework that will supersede the NVQ later this year.

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